BERNAU CAPITAL PARTNERS

Arona Corporation
Aterra Real Estate
Endurance Sports Marketing
First Iowa Title
Globe Acceptance
Ivy Lane Corporation
Hickory Park

2022 Benefits Guide

IMPORTANT CONTACTS

Resource	Carrier	Phone Number	Website/E-mail
Medical and Prescription	Wellmark BCBS	(800) 524-9242	www.wellmark.com
Dental	MetLife	(800) 942-0854	www.metlife.com
Vision	Avesis	(800) 828-9341	www.avesis.com
Life & Disability	MetLife	(800) 858-6506	www.metlife.com
Flexible Spending Accounts	HealthEquity	(866) 346-5800	www.healthequity.com
Health Savings Account	HealthEquity	(866) 346-5800	www.healthequity.com
Critical Illness & Accident	MetLife	(855) 564-6638	www.metlife.com
Holmes Murphy	Contact: Alesha Wilhite	(515) 518-2360	awilhite@holmesmurphy.com

This guide highlights the main features of many of the benefit plans sponsored by The Company. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. The Company reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

WHO IS ELIGIBLE

You are eligible to enroll in The Company's benefit plans if you are a regular, full-time employee scheduled to work at least 30 hours per week. As a regular, full-time employee, you are eligible for benefits on the first day of the month following 60 days of continuous service.

Dependent Eligibility

You may also cover your eligible dependents, including:

- Your legal spouse.
- Your eligible children up to age 26 for medical coverage; your unmarried, eligible children up to age 25 for dental and vision coverage.
- "Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

WHEN COVERAGE BEGINS

Initial Enrollment

When you first join The Company, you have 60 days to enroll yourself and your dependents for benefits. Coverage begins the first of the month following 60 days of employment.

If you fail to enroll in benefits when you are first eligible, you will automatically be enrolled in the Company Sponsored benefits. You will not be able to enroll in any other benefits until the next Annual Enrollment Period.

Annual Open Enrollment

During annual Open Enrollment, coverage takes effect on January 1 of the following year.

You will need to enroll in coverage on the Oasis portal. This is the same website you will use to access your pay stubs and W2 information. If you have misplaced your username or password, call (800) 336-1931 and select option 3.

Website:
https://portal.oasisassistant.com

MAKING CHANGES TO COVERAGE

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualified status change or you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualified status change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event by completing a Benefit Changes/Enrollment form and returning it to Human Resources. If you do not return your form within 31 days, you will have to wait until the next Open Enrollment to make new elections.

2022 SEMI-MONTHLY PREMIUMS

Coverage	Semi-Monthly Deduction
Wellmark $1,500 PPO	
Single	$131.03
Employee/Spouse	$363.05
Employee/Child(ren)	$319.49
Family	$624.98
Wellmark $2,000 PPO	
Single	$111.85
Employee/Spouse	$323.77
Employee/Child(ren)	$283.18
Family	$566.12
Wellmark $2,000 HMO	
Single	$27.77
Employee/Spouse	$279.58
Employee/Child(ren)	$242.33
Family	$424.89
Wellmark $5,000 PPO with Copays	
Single	$43.77
Employee/Spouse	$286.13
Employee/Child(ren)	$250.29
Family	$397.25
Wellmark $5,000 HDHP PPO	
Single	$37.15
Employee/Spouse	$221.38
Employee/Child(ren)	$190.43
Family	$300.21
Dental	
Single	$14.86
Employee/Spouse	$31.09
Employee/Child(ren)	$34.95
Family	$54.90
Vision	
Single	$3.44
Employee/Spouse	$6.64
Employee/Child(ren)	$6.64
Family	$9.72
Voluntary Life & STD	100%
Basic Life & LTD	Company Paid
Flexible Spending Account & Health Savings Account	100%
Other Voluntary Benefits	100%

MEDICAL PLAN

The Company's medical plans are provided by Wellmark BCBS. All plan options provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs, and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

Choosing a Medical Option

When it comes to medical coverage The Company offers, you have these choices:

- $1,500 PPO Plan
- $2,000 PPO Plan
- $2,000 HMO Plan **(Iowa Employees Only)**
- $5,000 PPO Plan
- $5,000 High Deductible Health Plan (HDHP)

Preferred Provider Organizations (PPO)

The PPO plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because network providers discount their fees. And, with in-network providers, you generally do not have to file claims.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.

High Deductible Health Plan

The High Deductible Health Plan (HDHP) works much like the PPO plan in that you can choose to receive care from in-network or out-of-network providers when you need medical care — and it covers the same types of services — but you pay less out of your paycheck for coverage. However, the HDHP has higher deductibles and no office visit copays. Once you've met the in-network or out-of-network deductible, you and the plan begin sharing expenses. Your portion of the expense is the coinsurance. **This also applies to prescription drugs, which are subject to the plan's deductibles. Once the deductible is met, you pay the applicable prescription drug cost or copay amount.**

In addition, the HDHP offers a tax-savings feature called the Health Savings Account (HSA). With this account, you can pay for certain out-of-pocket medical expenses throughout the year. You can also enroll in the Limited Purpose Flexible Spending Account to help you cover eligible out-of-pocket dental and vision expenses.

Health Maintenance Organization (HMO)

The $2,000 HMO plan is only available to employees who reside and seek medical care in the state of Iowa. There are no in-network providers outside of the states of Iowa & South Dakota. If you seek care from an out-of-network provider, you will not have coverage for those services. Life & limb threatening emergencies can be billed as in-network claims and would be paid the same as an in-network Emergency Room visit.

To find a provider, visit www.wellmark.com and click "Find a Provider". You can enter your location, network, and search criteria to find a provider that is in-network.

To find a provider, visit www.wellmark.com or log into your myWellmark account. Click on find a provider and enter your location, network, and search criteria.

MEDICAL PLAN COMPARISON – WELLMARK BCBS

	$1,500 PPO	$2,000 PPO	$2,000 HMO Iowa Only	$5,000 PPO	$5,000 HDHP
			In-Network		
Deductible[1,2]	Embedded	Embedded	Embedded	Embedded	Embedded
Individual	$1,500	$2,000	$2,000	$5,000	$5,000
Family	$3,000	$4,000	$4,000	$10,000	$10,000
Out-of-Pocket Maximum[1]					
Individual	$3,000	$6,000	$6,000	$5,000	$5,000
Family	$6,000	$12,000	$12,000	$10,000	$10,000
			You Pay		
Coinsurance	20%	20%	20%	0%	0%
Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge
Doctor on Demand	$20 Copay	$30 Copay	$30 Copay	$25 Copay	$59 Charge
Primary Care	$20 Copay	$30 Copay	$30 Copay	$25 Copay	Deductible
Specialist	$50 Copay	$50 Copay	$50 Copay	$50 Copay	Deductible
Urgent Care	$20 Copay	$30 Copay	$30 Copay	$25 Copay	Deductible
Emergency Room	$300 Copay	$300 Copay	$300 Copay	$300 Copay	Deductible
Inpatient Hospital	Deductible, 20%	Deductible, 20%	Deductible, 20%	Deductible	Deductible
Outpatient Surgery	Deductible, 20%	Deductible, 20%	Deductible, 20%	Deductible	Deductible
			Out-of-Network		
Deductible[1,2]					
Individual	$2,000	$2,500	Not Covered	$6,000	$5,000
Family	$4,000	$5,000	Not Covered	$12,000	$10,000
Out-of-Pocket Maximum[1]					
Individual	$4,000	$6,000	Not Covered	$10,000	$10,000
Family	$8,000	$12,000	Not Covered	$20,000	$20,000
Coinsurance	30%	30%	Not Covered	30%	30%

(1) In and out-of-network deductibles and out-of-pocket maximums do not apply to each other.
(2) Member has benefits when single deductible is met regardless of coverage tier.

PRESCRIPTION DRUG COVERAGE

If you enroll in one of the Company medical plans, you will automatically receive prescription drug coverage through CVS. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are generally not covered.

Mail Order Program

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). When you use the mail order program, you receive a 3-month supply of medication. Your medications are mailed directly to your home. To order prescriptions through the mail order program, you must fill out a mail order form and return it with a 90-day prescription from your doctor and your payment. Mail order forms are available through CVS.

Specialty Prescription Program

If you have a chronic condition and take specialty medications, you must purchase these through a designated specialty pharmacy that provides the best available pricing and additional support. If you have a prescription that meets this requirement, BCBS will contact you and provide you with the necessary information to fill your prescription.

Prescription Drug Plan Highlights

	$1,500 PPO	$2,000 PPO	$2,000 HMO	$5,000 PPO	$5,000 HDHP
Retail Prescription Copays (up to 31-day supply)					
Rx Deductible	$100 Single / $300 Family	$100 Single / $300 Family	$100 Single / $300 Family	$100 Single / $300 Family	None
Tier 1 (deductible waived)	$10 Copay	$10 Copay	$10 Copay	$10 Copay	Deductible
Tier 2	$30 Copay	$30 Copay	$30 Copay	$30 Copay	Deductible
Tier 3	$50 Copay	$50 Copay	$50 Copay	$50 Copay	Deductible
Tier 4	$50 Copay	$50 Copay	$50 Copay	$50 Copay	Deductible
Specialty Preferred	$100 Copay	$100 Copay	$100 Copay	$100 Copay	Deductible
Specialty Non-Preferred	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	Deductible

What's a Health Savings Account?

A Health Savings Account (HSA) is a tax-free account that earns interest. You can set up an HSA through a bank or through HealthEquity, our HSA vendor, and make contributions to your account from your paychecks throughout the year. Then, you can use the HSA to pay for eligible health care expenses, such as deductibles, coinsurance, and other out-of-pocket dental, vision, and prescription drug expenses not covered by a health plan. Your account balance can carry over from year to year, and you can take it with you if you leave the company.

The IRS sets maximum limits for Health Savings Accounts. Below are the maximum limits for 2022.

Coverage Level	Total HSA Contribution Allowed Per Year
Employee Only	$3,650
Employee + Family	$7,300
Catch-Up for Age 55+	$1,000 annually

Who Is Eligible for the HSA?

You can participate in the HSA only if you enroll in the HDHP. You are not eligible to contribute if:

- You are enrolled in Medicare.
- You are covered by another medical plan (such as your spouse's plan) that does not qualify as a high deductible health plan.
- You or your spouse participates in a Health Care Flexible Spending Account (FSA) (through your employer or at your spouse's employer.)

How to Use the HSA to Pay for Care

Once you've set up your HSA, you will receive a debit card specifically for your account. Then, when you have an eligible expense, you have several choices for how to pay:

1. **Pay with your HSA debit card** if you have funds available in your account.
2. **Write a check from your HSA.** You must order checks when you enroll in the HSA to have this option. And, as with any other type of check, you must have funds available or the check will be returned — and you will be charged an insufficient funds fee.
3. **Pay for expenses out of your own pocket**, and then reimburse yourself from your HSA.

What are the Advantages of an HSA?

- Monies go in tax-free
- Monies grow tax-free if you choose to invest your HSA dollars
- Monies come out tax-free as long as they are used to pay for qualified medical expenses (including things like dental and vision expenses)
- Unspent monies roll over year to year
- The account owner (you!) decides whether to use the HSA dollars for current expenses, or to save them for future expenses
- You take the account with you

HealthEquity®

TAX SAVINGS. HEALTH SAVINGS. WOW SAVINGS.

Take control of your health and grow your money. See the power of an HSA-qualified health plan combined with a HealthEquity HSA.

SAVE ON PREMIUMS

When it comes to choosing a healthcare plan, you really have one decision to make: High premium or low premium?

HSA-qualified health plans (sometimes called high-deductible or consumer choice health plans) offer the lowest premiums, enabling you to unlock immediate savings. The difference could be thousands of dollars every year.

KEEP YOUR PREMIUM SAVINGS

Healthcare premium payments disappear forever. But you can use your HealthEquity HSA to keep that money instead.

Choose a low premium health plan. Then just put the extra money you would have paid toward traditional premiums into your HSA. Voila! Long-term health savings.

Want to go bigger? Don't forget IRS annual contribution limits.

	Individual Plan	Family Plan
2020	**$3,550**	**$7,100**
2021	**$3,600**	**$7,200**
Members 55+ can contribute an **extra $1,000**		

You have until April 15 to max your contributions for the previous tax year.

MAXIMIZE TAX SAVINGS

Every dollar you contribute pre-tax to your HSA reduces your annual taxable income.

Plus, you automatically earn tax-free interest on your money. Anytime healthcare expenses come up just pay from your HSA and you're good to go. You never pay taxes or penalties when you use HSA dollars for qualified medical expenses.

See the savings for yourself

Try our plan comparison tool to see how much an HSA-qualified health plan will save you this year.

Visit CompareMyHSA.com

HSA dollars are yours to keep

Unlike flexible spending accounts (FSA), you never lose your HSA dollars. Money in your account rolls over year after year, even if you change health plans or employers.

Spend smarter

HSAs cover thousands of qualified medical expenses, including doctor visits and over-the-counter medications. See a full list of eligible expenses.

Visit HealthEquity.com/QME

HSA triple-tax advantage[1]

1. Make pre-tax contributions
2. Grow tax-free earnings
3. Enjoy tax-free distribution[2]

ACCELERATE LONG-TERM SAVINGS

So now you're saving on premiums, building health savings and also saving big on taxes. What's next?

Add some sizzle to your savings by investing in low-cost mutual funds.[4] It's easier than ever to invest. Just log into your account and a helpful step-by-step tutorial will walk you through the process. Do it yourself or let intelligent technologies do the work.

ADVISOR™
powered by: HealthEquity ADVISORS, LLC

Choose from two powerful advisory tools brought to you by HealthEquity Advisors, LLC™

GPS

Tap into algorithm-based guidance and recommendations

GPS suggests investment options based on age, investment objectives, investment experience and more. This option gives members the opportunity to ultimately select their own investments based on targeted advice.

AUTOPILOT

Let intelligent technologies manage your entire portfolio

Member inputs create a risk profile, then **AutoPilot** will automatically rebalance member portfolios based on specified factors. **AutoPilot** empowers even the most inexperienced members to invest confidently.

Be retirement ready

Your HealthEquity HSA works like a second 401(k). After you're 65, you can withdraw HSA dollars for any expense—you'll just need to pay ordinary income taxes. Of course, if you use that money for qualified medical expenses, you never pay taxes at all.[3]

It's not just an HSA—it's your nest egg.

CONNECTING HEALTH AND WEALTH

Maybe you've had an HSA before, but you've never had an HSA like this.

Get support 24/7
Call us day or night. Our US-based service team measures success by problems solved. We'll do whatever it takes.

Say goodbye to hassle
Log in and manage everything via our simple mobile app.[5] Want to submit a claim? Easy. Just snap a photo and you're on your way.

Be inspired
Check out our vast library of webinars, tutorials, videos, calculators, and more. You'll find tips and tricks to make the most of your HSA.

Join five million+ health savers
For more than two decades we've empowered some of the biggest companies in the world—and the smartest savers on the block.

Enroll today. Talk to your benefits team.
866.735.8195 | HealthEquity.com/Learn

[1] HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

[2] For qualified medical expenses

[3] After age 65, if you withdraw funds for any purpose other than qualified medical expenses, you will be subject to income taxes. Funds withdrawn for qualified medical expenses will remain tax-free.

[4] Investments are subject to risk, including the possible loss of the principal invested and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. HealthEquity Advisors, LLC™, a wholly owned subsidiary of HealthEquity, Inc. and an SEC-registered investment adviser, provides web-based investment advice to HSA holders that subscribe for its services (minimum thresholds and additional fees apply). Investing may not be suitable for everyone and before making any investments, review the fund's prospectus.

[5] Accounts must be activated via the HealthEquity website in order to use the mobile app.

HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life changing decisions.

 HSA_Brochure_September_2020.pdf

DENTAL PLAN

The Dental Plan is administered through MetLife and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings, and orthodontia for children.

The Dental PPO allows you the freedom to visit any dentist, without referrals, for all of your dental care. If you receive care from one of MetLife's preferred dentists, you'll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher and you may need to file your own claims.

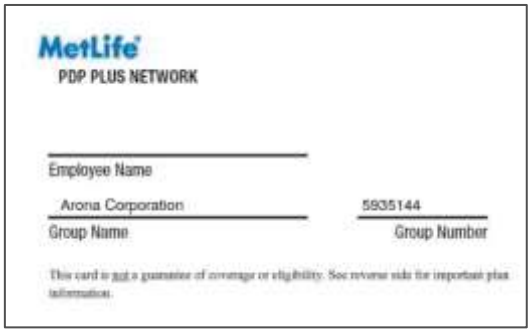
For a list of MetLife preferred dentists, go to **www.metlife.com**.

DENTAL PLAN HIGHLIGHTS

Plan Feature	Premium Plan – PPO
Annual Deductible Individual Family	 $50 $150
Annual Benefit Maximum	$2,000/person
Preventive Services (Exams, routine cleanings, fluoride treatments, space maintainers)	Deductible waived, covered at 100%
Basic Services (X-rays, fillings, sealants, denture repairs)	Deductible, 20% coinsurance
Major Services (Crowns, inlays, onlays, bridges, dentures)	Deductible, 50% coinsurance
Orthodontia – children up to age 19	50% coinsurance up to lifetime maximum of $1,000 per dependent child

Out-of-Network benefits are reimbursed based on Reasonable & Customary charge. Reasonable & Customary is based on the lowest the dentist's actual charge or charge of most dentists in the area for the same or similar services.

DENTAL ID CARD – METLIFE DOES NOT MAIL ID CARDS TO YOUR HOME



VISION PLAN

The Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through Avesis.

Vision Coverage

If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the Avesis network, you will receive a discount on services. To find a network provider, go to www.avesis.com

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Vision Plan Highlights

	In-Network	Out-of-Network
Plan Feature	**You Pay**	**Reimbursement**
Exam	$10 copayment	Reimbursed up to $45
Prescription Glasses Benefits		
Single Lenses	$10 copayment	Reimbursed up to $30
Bifocals – Lined	$10 copayment	Reimbursed up to $50
Trifocals – Lined	$10 copayment	Reimbursed up to $65
Frames	$50 Wholesale Allowance	Reimbursed up to $70
Contact Benefits		
Elective Contacts	Reimbursed up to $130	Reimbursed up to $105
Medically Necessary Contacts	$10 copayment	Reimbursed up to $210
Benefit Frequency		
Exam	Vision Exam every 12 months	
Frames	Frames every 24 months	
Lenses	Spectacle Lenses every 12 months	
Contacts	Contact Lenses every 12 months	

BASIC LIFE & AD&D INSURANCE

The Company offers life and accidental death and dismemberment insurance coverage to provide financial protection in the event you or your dependents pass away while you are still working. This coverage is administered through MetLife.

Basic Life & AD&D Insurance

The Company automatically provides Basic Life Insurance and Accidental Death and Dismemberment for all eligible employees at no cost. Basic Life Insurance is a flat benefit of $15,000 for all employees. The benefit is paid to your beneficiaries in the event of your death. AD&D is paid if you pass away or are dismembered due to an accident.

VOLUNTARY LIFE & AD&D COVERAGE

In addition to Basic Life/AD&D Insurance, you may also purchase Optional Life/AD&D Insurance for you and your eligible dependents. You pay for this coverage on a pre-tax basis through payroll deductions. If you waive coverage when you are first eligible, future elections will be subject to Evidence of Insurability and must be approved by MetLife.

Rates can be found by logging into Oasis.

Optional Life Insurance Coverage

Coverage For	Coverage Available	Guarantee Issue Amounts(1)
Employee	Up to 5x salary; $10,000 increments up to a maximum of $500,000	$100,000
Spouse	$5,000 increments up to a maximum of $100,000	$25,000
Child(ren)	$1,000 increments up to a maximum of $10,000	All Amounts

(1) Employees and spouses are eligible for amounts up to the guaranteed issue amount if coverage is elected when newly eligible. If you waive coverage as a new hire, any amounts elected in the future will be subject to Evidence of Insurability and must be approved by the carrier.

Beneficiary Designation

You must designate a beneficiary for Basic Life & Voluntary Life Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You can change your beneficiaries at any time during the year.

If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

You are automatically the beneficiary for policies purchased on your spouse or children.

Benefits Reduce at Age 65

When you reach age 65, Basic & Voluntary Life Insurance benefits are reduced to 65% of the original face value of the policy. Once you reach age 70, benefits are reduced to 50% of the original face value of the policy. For more information, refer to your Group Life Insurance booklet.

If you terminate employment, you have the option to port or convert your coverage if you apply with MetLife within 31 days of termination.

DISABILITY COVERAGE

The Company offers you two disability plans that work together to keep all or part of your paycheck coming if you cannot work because of illness, injury, or pregnancy. Disability benefits are administered through MetLife.

Short-Term and Long-Term Disability have a pre-existing condition waiting period of 3/12. This means if you have been treated for or diagnosed with a medical condition within 3 months of your effective date, benefits are not payable for that condition for a period of 12 months.

VOLUNTARY SHORT-TERM DISABILITY

Voluntary Short-Term Disability (STD) benefits are paid for through payroll deduction and you pay 100% of the cost if you choose to enroll. Your STD benefits will replace 60% of your base pay, up to $1,000 per week. Your STD benefits begin on the 8th calendar day of your disability if you are unable to work. The maximum benefit available is 26 weeks per STD claim.

To determine your monthly premium, refer to the chart below. The maximum benefit amount cannot exceed 60% of your gross weekly earnings or $1,000, whichever is less (rounded down to the nearest $50).

Weekly Benefit	Employee's Age								
	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
$100	$4.89	$4.89	$4.89	$4.89	$5.87	$7.47	$10.49	$12.53	$13.42
$150	$7.34	$7.34	$7.34	$7.34	$8.80	$11.20	$15.74	$18.80	$20.13
$200	$9.78	$9.78	$9.78	$9.78	$11.74	$14.94	$20.98	$25.06	$26.84
$250	$12.22	$12.22	$12.22	$12.22	$14.68	$18.68	$26.22	$31.32	$33.55
$300	$14.67	$14.67	$14.67	$14.67	$17.61	$22.41	$31.47	$37.59	$40.26
$350	$17.12	$17.12	$17.12	$17.12	$20.54	$26.14	$36.72	$43.86	$46.97
$400	$19.56	$19.56	$19.56	$19.56	$23.48	$29.88	$41.96	$50.12	$53.68
$450	$22.00	$22.00	$22.00	$22.00	$26.42	$33.62	$47.20	$56.38	$60.39
$500	$24.45	$24.45	$24.45	$24.45	$29.35	$37.35	$52.45	$62.65	$67.10
$550	$26.90	$26.90	$26.90	$26.90	$32.28	$41.08	$57.70	$68.92	$73.81
$600	$29.34	$29.34	$29.34	$29.34	$35.22	$44.82	$62.94	$75.18	$80.52
$650	$31.78	$31.78	$31.78	$31.78	$38.16	$48.56	$68.18	$81.44	$87.23
$700	$34.23	$34.23	$34.23	$34.23	$41.09	$52.29	$73.43	$87.71	$93.94
$750	$36.68	$36.68	$36.68	$36.68	$44.02	$56.02	$78.68	$93.98	$100.65
$800	$39.12	$39.12	$39.12	$39.12	$46.96	$59.76	$83.92	$100.24	$107.36
$850	$41.56	$41.56	$41.56	$41.56	$49.90	$63.50	$89.16	$106.50	$114.07
$900	$44.01	$44.01	$44.01	$44.01	$52.83	$67.23	$94.41	$112.77	$120.78
$950	$46.46	$46.46	$46.46	$46.46	$55.76	$70.96	$99.66	$119.04	$127.49
$1,000	$48.90	$48.90	$48.90	$48.90	$58.70	$74.70	$104.90	$125.30	$134.20

If you waive coverage when you are first eligible, you are limited to electing $100 in coverage at future enrollment periods. you may increase your election by $50 per enrollment period after that.

LONG-TERM DISABILITY

If you remain totally disabled and unable to work for more than 26 weeks, you may be eligible for Long-Term Disability (LTD) benefits. The Company automatically provides you LTD benefits that replace up to 60% of your base pay, up to a maximum of $5,000 per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

You can continue to receive LTD benefits for up to a period of 24 months if you are unable to work in your own occupation. After 24 months, you may continue receiving LTD benefits if you are unable to work in any occupation.

FLEXIBLE SPENDING ACCOUNTS

The Company allows you to contribute to one or both Flexible Spending Accounts (FSAs), which allow you to save taxes on certain out-of-pocket health care and dependent care expenses. The FSAs are administered by HealthEquity.

How the FSAs Work

The Company offers two types of FSAs:

- Health Care FSA
- Dependent Care FSA

If you elect to contribute to one or both of the FSAs, you choose an annual amount to be taken from each of your paychecks and deposited into your account throughout the year. Your contributions are taken out of your paycheck before you pay taxes, so you save money. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year.

With both accounts, the IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the "use it or lose it" rule.

The Company FSA plan allows a 2.5 month extension of time at the end of the 12 month plan year in which you may continue to incur eligible expenses and submit them for reimbursement. After 2.5 months, you will forfeit any money that remains in the account.

Annual Contribution Amount

You can contribute up to **$2,750 per year** to the Health Care FSA.

Health Care FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses. Examples include, but are not limited to:

- Medical or dental deductibles
- Office visit copays
- Coinsurance amounts
- Amounts you pay for prescription drugs
- Amounts you pay for certain over-the-counter items
- Eyeglasses, contacts, and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by the dental plan

How the Debit Card Works

If you enroll in the Health Care FSA, you will receive a debit card in the mail from HealthEquity.

You can use your debit card at certain places to pay for eligible expenses up-front, such as prescription drugs and office visit copays, without having to pay with cash and wait for a reimbursement. **You will need to submit your receipts as substantiation of your expense, so it's important to keep them.**

If you choose not to use your debit card, you can always pay for your eligible expense and file a claim for reimbursement.

If you enroll in the High Deductible Health Plan for medical coverage, which has a Health Savings Account (HSA), you cannot enroll in the Health Care FSA.

Dependent Care FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be employed, a full-time student at least five months during the plan year, or mentally or physically disabled and unable to provide care for himself or herself.
- For the Dependent Care FSA, you may only be reimbursed up to the amount in your account at the time you file a claim. If your eligible expenses are greater than the amount in your account, the unreimbursed amount will carry over and be reimbursed after your next deposit. (For the Health Care FSA, you can be reimbursed up to the full amount you have elected to contribute for the year — even if you have not yet contributed that much to your account.)
- If you use the Dependent Care FSA, you must provide your caregiver's Social Security number or tax ID when you file a claim for reimbursement.
- The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other. You also cannot transfer funds between the two accounts.

In some cases, a federal child-tax credit may save you more money than the Dependent Care FSA. You may want to consult a tax advisor to find which option is better for you.

Eligible Dependent Care Expenses

Generally, you may use the money in your Dependent Care FSA for care for:

- Your children under age 13 whom you claim as a dependent for tax purposes.
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).

Some typical expenses that are eligible for reimbursement under the plan are:

- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- Day camps
- After-school care

Annual Contribution Amount

You can contribute up to **$5,000 per year** to the Dependent Care FSA. If you are married and you and your spouse file separate tax returns, the maximum you can contribute is $2,500.

HealthEquity® | WageWorks

P.O. Box 60010 Phoenix, AZ 85082-0010

QUICKSTART GUIDE

Your Flexible Spending Account

At-a-Glance

Register online now!

If you haven't registered online yet, please do so today. To register, just visit **www.healthequity.com/wageworks**, select "LOG IN/REGISTER" and then "Employee Registration." You'll need to answer a few simple questions and create a username and password.

Questions?

HealthEquity makes it easy for you to get the help you need now. Please call us at 877.924.3967 or visit the Support Center at **www.healthequity.com/wageworks** where you will find answers to frequently asked questions, important forms, videos and other useful resources.

Download the EZ Receipts® mobile app!

Use your mobile device to file claims and take care of your account paperwork from anywhere. Go to **www.healthequity.com/wageworks** to learn more.

Welcome to HealthEquity. Start Saving. Here's How.

Welcome to your healthcare and/or dependent care flexible spending account (FSA) sponsored by your employer and brought to you by HealthEquity.

Your FSA is a great way to save on hundreds of eligible expenses like prescriptions, copayments, over-the-counter (OTC) items, and child and elder care.

Your FSA: The Essentials

Your FSA is governed by IRS regulations that detail who is eligible to use the account and where and how the money in it is to be used. Your FSA was designed to be simple. To keep it that way, it's important to comply with the IRS regulations that govern the program. The following guidelines will help you avoid any inconvenience.

- **Make sure account funds are only spent on expenses for those who are eligible.** Typically, those eligible are you, your spouse and your eligible dependents.
- **Know what expenses are eligible.** Log in to your account at **www.healthequity.com/wageworks** for a complete list of eligible healthcare expenses. Generally, eligible healthcare expenses include services and products that are medically necessary to treat a specific condition. Dependent care expenses typically include care provided for your qualifying child (under age 13) or other qualifying dependent so you can work.
- **Keep your receipts.** Save receipts that describe exactly what you paid for. Make sure the amount and service date—not the payment date—are included.
- **Over-the-counter (OTC) medications, drugs and menstrual care products.** You can use your HealthEquity® Visa® Healthcare Card (Card) for OTC medications and drugs, including menstrual care products. Alternatively, you can pay for the item out of pocket and use Pay Me Back to submit your claim to HealthEquity for reimbursement. Pay Me Back claims can be submitted online, or with your smartphone or mobile device. (FSA plans vary by employer, and these changes do not necessarily change the benefits under your employer's plan.)
- **Watch where you shop.** If using a HealthEquity Healthcare Card, shop only at general merchandise stores or pharmacies that have an IRS-approved inventory system in place. Visit **www.sigis.com** for the most updated list of approved merchants. The healthcare Card will not work at a non-certified merchant.
- **Verify all healthcare Card transactions.** If a transaction is not automatically verified at checkout or by a third-party system, you will be notified by email or upon login to your account. Failure to verify an outstanding transaction may result in healthcare Card suspension.
- **Register for an online account at www.healthequity.com/wageworks.** When you register online and provide a current email, you ensure that you will have 24/7 access to your account and will be automatically signed up to receive important updates and alerts. You also must have an account to use the mobile app and take advantage of features like Submit Receipt or Claim and healthcare Card usage requests.
- **Keep track of your FSA balance.** Plan ahead to make sure you spend the full amount of your balance

PE-301-FSA-QS-XXX

QUICKSTART GUIDE

Managing Your Account

You can manage and check up on your account through HealthEquity online or over the phone. The "Claims and Activity" page online details all your account activity and will even alert you if any healthcare Card transactions are in need of verification.

For the latest information, visit **www.healthequity.com/wageworks** and log in to your account 24/7. In addition to reviewing your most recent FSA activity, you can:

- Update your account preferences and personal information.
- View your transactions and account history.
- Schedule payments to healthcare and dependent care providers.
- Check the complete list of eligible expenses for your FSA program.
- Order additional HealthEquity Healthcare Cards for your family.
- Download the EZ Receipts app to file claims and healthcare Card use paperwork.

Using Your FSA Dollars

When you pay for a eligible healthcare and dependent care expense, you want to put your FSA to work right away. HealthEquity gives you several options to use your money the way you choose.

Using your HealthEquity Healthcare Card

Use your HealthEquity Healthcare Card (Card) instead of cash or credit at healthcare providers and pharmacies for eligible services, goods and prescriptions. You can also use the healthcare Card at general merchants and drug stores that have an industry standard (IIAS) checkout system that can automatically verify if the item is eligible for purchase with your account.

- Go to **www.sigis.com** to review a list of eligible merchants, like drug stores, supermarkets and warehouse stores, that accept the healthcare Card.
- When you swipe your healthcare Card at the checkout, choose "credit" (even though it isn't a credit card).
- Consider paying for items or services on the day you receive them. If your health plan covers a portion of the cost, make sure you know what amount you need to pay before using the healthcare Card, by presenting your health plan member ID card first, so the merchant can identify your copay or coinsurance amount and ensure the service is claimed to your healthcare, dental, or vision insurance plan.
- Save your receipts or digital copies. You will need them for tax purposes. Plus, even when your healthcare Card is approved, a detailed receipt may still be requested.
- If you've lost or can't produce a receipt for an expense, your options may range from submitting a substitute receipt to paying back the plan for the amount of the transaction.
- If you use your healthcare Card at an eye doctor's or dentist's office, we will most likely ask you to submit an Explanation of Benefits (EOB) or other documentation for verification. Failure to do may result in your healthcare Card being suspended.
- If you lose your healthcare Card, please call HealthEquity immediately and order a new one. You will be responsible for any charges until you report the lost healthcare Card.

Using your Mobile Device

With the EZ Receipts mobile app, you can file and manage your reimbursement claims and healthcare Card usage paperwork on the spot, with a click of your mobile device camera, from anywhere.

To use EZ Receipts:

- Download at **www.healthequity.com/wageworks/employees/go-mobile**.
- Log in to your account.
- Choose the type of receipt from the simple menu.
- Enter some basic information about the claim or healthcare Card transaction.
- Use your mobile device camera to capture the documentation.
- Submit the image and details to HealthEquity.

Paying online

You can pay many of your eligible healthcare and dependent care expenses directly from your FSA with no need to fill out paper forms.* It's quick, easy, secure and available online at any time.

To pay a provider:

- Log in to your FSA at **www.healthequity.com/wageworks**.
- Select "Submit Receipt or Claim."
- Request "Pay My Provider" from the menu and follow the instructions.
- Make sure to provide an invoice or appropriate documentation. When you're done, HealthEquity will schedule the checks to be sent in accordance with the payment guidelines. If you pay for eligible, recurring expenses, follow the online instructions to set up automatic payments.

* You must, however, provide documentation. For more information about the documentation requirements and payment guidelines, visit **www.healthequity.com/wageworks**.

Filing a claim

You also can file a claim online to request reimbursement for your eligible healthcare and dependent care expenses.

- Go to **www.healthequity.com/wageworks**, log in to your account and select "Submit Receipt or Claim."
- Select "Pay Me Back."
- Fill in all the information requested on the form and submit.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.
- Make sure your documentation includes the five following pieces of information required by the IRS:
  - Date of service or purchase
  - Detailed description
  - Provider or merchant name
  - Patient name
  - Patient portion or amount owed

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

If you prefer to submit a paper claim by fax or mail, download a Pay Me Back claim form at **www.healthequity.com/wageworks** and follow the instructions for submission.

HealthEquity®

OTHER VOLUNTARY BENEFITS

Critical Illness Coverage

The Company provides Critical Illness insurance that you can purchase through MetLife. The cost of this coverage is paid for through post-tax payroll deduction and is 100% paid by you.

Employee's can purchase a flat benefit amount of $15,000 or $30,000 which would be paid to you in a lump sum if you were to be diagnosed with a covered Critical Illness. Benefits can also be purchased for your spouse and children. More information can be found on the Plan Summary page that follows.

Accident Coverage

The company provides two Accident plans that you can purchase through MetLife. The cost of this coverage is paid for through post-tax payroll deduction and is 100% paid by you.

You have the option of purchasing the High Plan or the Low Plan. Both plans pay you based on a schedule of benefits when you are injured in an accident. The High Plan is more expensive, but pays a higher benefit when you are injured or receive treatment due to an accident. The Low Plan is the cheaper option, but pays a lesser benefit at the time of a claim. You can choose to cover yourself, your spouse, and your children.

LifeLock Identity Theft Protection

You also have the option to enroll in Identity Theft Protection through LifeLock. There are two options for you to enroll in – standard identity theft protection or LifeLock Ultimate, which is a comprehensive identity protection service. More information on the options available through LifeLock can be found late in the packet.

MetLife Critical Illness Insurance Plan Summary

COVERAGE OPTIONS

Critical Illness Insurance		
Eligible Individual	**Initial Benefit**	**Requirements**
Employee	**Initial Benefit Amount of $15,000 or $30,000**	Coverage is guaranteed provided you are actively at work.[3]
Spouse	**100% of the employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]
Dependent Child(ren)[2*]	**100% of the employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]

BENEFIT PAYMENT

Your **Initial Benefit** provides a lump-sum payment upon the first diagnosis of a Covered Condition. Your plan pays a Recurrence Benefit[4] equal to the Initial Benefit for the following Covered Conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer and Partial Benefit Cancer. A Recurrence Benefit is only available if an Initial Benefit has been paid for the Covered Condition. There is a Benefit Suspension Period between Recurrences.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the **Total Benefit** and is [3] times the amount of your Initial Benefit.

Please refer to the table below for the percentage benefit amount for each Covered Condition.

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer[5]	100% of Initial Benefit	100% of Initial Benefit
Partial Benefit Cancer[5]	25% of Initial Benefit	25% of Initial Benefit
Heart Attack	100% of Initial Benefit	100% of Initial Benefit
Stroke[5]	100% of Initial Benefit	100% of Initial Benefit
Coronary Artery Bypass Graft[6]	100% of Initial Benefit	100% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not applicable
Alzheimer's Disease[7]	100% of Initial Benefit	Not applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not applicable
22 Listed Conditions[8]	25% of Initial Benefit	Not applicable

Example of Initial & Recurrence Benefit Payments
The example below illustrates an employee who elected an Initial Benefit of $15,000 and has a Total Benefit of 3 times the Initial Benefit Amount or $45,000.

Illness – Covered Condition	Payment	Total Benefit Remaining
Heart Attack – first diagnosis	Initial Benefit payment of $15,000 or 100%.	($30,000)
Heart Attack – second diagnosis, two years later	Recurrence Benefit payment of $15,000 or 100%	($15,000)
Kidney Failure – first diagnosis, three years later	Initial Benefit payment of $15,000 or 100%	($0)

SUPPLEMENTAL BENEFITS

MetLife provides coverage for the Supplemental Benefits listed below. This coverage would be in addition to the Total Benefit Amount payable for the previously mentioned Covered Conditions.

Health Screening Benefit[9]
After your coverage has been in effect for thirty days, MetLife will provide an annual benefit of $50 or $100* per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year. For a complete list of eligible screening/prevention measures, please refer to the Disclosure Statement/Outline of Coverage.

*The Health Screening Benefit amount depends upon the Initial Benefit Amount selected. Employees would receive a $50 benefit with the $15,000 initial benefit amount or a $100 benefit with the $30,000 Initial Benefit Amount.

QUESTIONS & ANSWERS

Who is eligible to enroll?
Regular active full-time employees who are actively at work along with their spouse and dependent children can enroll for MetLife Critical Illness Insurance coverage.[3]

How do I pay for coverage?
Coverage is paid through convenient payroll deduction.

If I Leave the Company, Can I Keep My Coverage? [10]
Under certain circumstances, you can take your coverage with you if you leave. You must make a request in writing within a specified period after you leave your employer. You must also continue to pay premiums to keep the coverage in force.

Who do I call for assistance?
Please call MetLife at 1-855-564-6638 and speak with a benefits consultant.

PREMIUMS

Monthly Premium for $1,000 of Coverage

Attained Age	Employee Only	Employee +Spouse	Employee +Children	Employee +Spouse/ Children
<25	$0.43	$0.87	$0.95	$1.39
25–29	$0.46	$0.92	$0.98	$1.44
30–34	$0.64	$1.24	$1.16	$1.76
35–39	$0.93	$1.76	$1.45	$2.28
40–44	$1.44	$2.67	$1.96	$3.19
45–49	$2.24	$4.08	$2.76	$4.60
50–54	$3.39	$6.03	$3.91	$6.55
55–59	$4.91	$8.56	$5.43	$9.08
60–64	$7.21	$12.42	$7.73	$12.94
65–69	$11.03	$18.75	$11.55	$19.27
70+	$16.40	$28.35	$16.92	$28.87

Example:
$15,000 in coverage for 34 yo employee only
$15,000 / $1,000 = 15
15 x $.64 = $9.60 per month

MetLife

MetLife Accident Insurance Plan Summary

ACCIDENT INSURANCE BENEFITS

With MetLife, you'll have a choice of 2 comprehensive plans which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered events/services.

Benefit Type[1]	Low Plan MetLife Accident Insurance Pays YOU	High Plan MetLife Accident Insurance Pays YOU
Injuries		
Fractures[2]	$50 – $3,000[2]	$100 – $6,000[2]
Dislocations[2]	$50 – $3,000[2]	$100 – $6,000[2]
Second and Third Degree Burns	$50 – $5,000	$100 – $10,000
Concussions	$200	$400
Cuts/Lacerations	$25 – $200	$50 – $400
Eye Injuries	$200	$300
Medical Services & Treatment[1]		
Ambulance	$200 – $750	$300 – $1,000
Emergency Care	$25 – $50	$50 – $100
Non-Emergency Care	$25	$50
Physician Follow-Up	$50	$75
Therapy Services (including physical therapy)	$15	$25
Medical Testing Benefit	$100	$200
Medical Appliances	$50 – $500	$100 – $1,000
Inpatient Surgery	$100 – $1,000	$200 – $2,000
Hospital[3] Coverage (Accident)		
Admission	$500 – $1,000 per accident	$1,000 – $2,000 per accident
Confinement (non-ICU confinement paid for up to 365 days. ICU confinement paid for 30 days)	$100 (non-ICU) – $200 (ICU) a day	$200 (non-ICU) – $400 (ICU) a day
Inpatient Rehab (paid per accident)	$100 a day, up to 15 days	$200 a day, up to 15 days
Hospital Coverage (Sickness)[4]		
Admission (payable 1 x per calendar year)	$150 (non-ICU) – $300 (ICU)	$150 (non-ICU) – $300 (ICU)
Confinement (paid per sickness)	$100 (non-ICU) – $200 (ICU) Payable up to 30 days per sickness	$100 (non-ICU) – $200 (ICU) Payable up to 30 days per sickness

Benefit Type[1]	Low Plan MetLife Accident Insurance Pays YOU	High Plan MetLife Accident Insurance Pays YOU
Accidental Death		
Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of amount shown.	$25,000 $75,000 for common carrier[5]	$50,000 $150,000 for common carrier[5]
Dismemberment, Loss & Paralysis		
Dismemberment, Loss & Paralysis	$250 – $10,000 per injury	$500 - $50,000 per injury

BENEFIT PAYMENT EXAMPLE

Kathy's daughter, Molly, plays soccer on the varsity high school team. During a recent game, she collided with an opposing player, was knocked unconscious and taken to the local emergency room by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event[1]	Benefit Amount[8]
Ambulance (ground)	**$300**
Emergency Care	**$100**
Physician Follow-Up ($75 x 2)	**$150**
Medical Testing	**$200**
Concussion	**$400**
Broken Tooth (repaired by crown)	**$200**
Benefits paid by MetLife Group Accident Insurance	**$1,350**

QUESTIONS & ANSWERS

Who is eligible to enroll for this accident coverage?
You are eligible to enroll yourself and your eligible family members![9] You need to enroll during your Enrollment Period and be actively at work for your coverage to be effective.

How do I pay for my accident coverage?
Premiums will be conveniently paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

What happens if my employment status changes? Can I take my coverage with me?
Yes, you can take your coverage with you. You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Who do I call for assistance?
Please call MetLife at 1-855-564-6638 and speak with a benefits consultant.

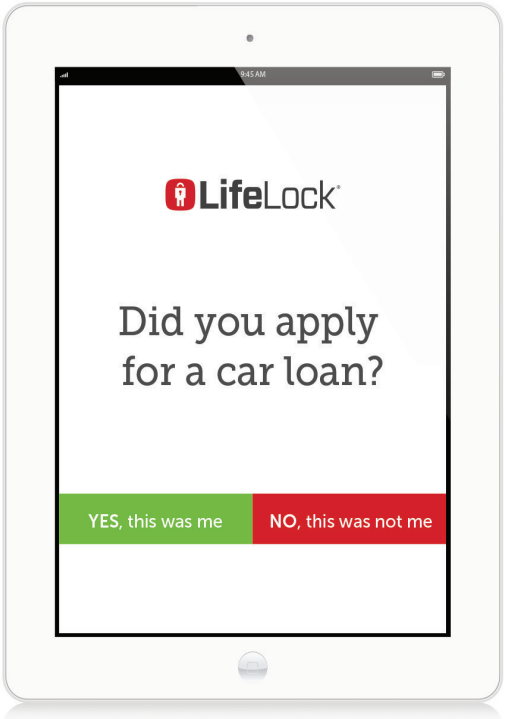
PREMIUMS

Low Plan	
Coverage Tier	Semi-Monthly Amount
Employee	$5.87
Employee+Spouse	$9.11
Employee+Child(ren)	$10.63
Family	$14.16

High Plan	
Coverage Tier	Semi-Monthly Amount
Employee	$11.22
Employee+Spouse	$17.40
Employee+Child(ren)	$20.28
Family	$27.02

Protecting Your Personal Information is Our Top Priority

LifeLock helps safeguard your finances, credit & good name.



ENROLL IN PROACTIVE IDENTITY THEFT PROTECTION.

LifeLock Identity Theft Protection® detects your personal information in applications for credit and services within our extensive network.† We monitor over a trillion data points, including those for new credit cards, wireless services, retail credit, mortgages, auto and payday loans. You can respond immediately to confirm if the activity is fraudulent with our proprietary Not Me® verification technology. If identity fraud does occur, our Certified Resolution Specialists are available to personally manage your case from beginning to end.

†Network does not cover all transactions.
‡The benefits under the Service Guarantee are provided under a Master Insurance Policy underwritten by State National Insurance Company. As this is only a summary please see the actual policy for applicable terms and restrictions at LifeLock.com/legal

LifeLock BENEFIT SOLUTIONS

THE NECESSARY, VOLUNTARY BENEFIT

Choose the LifeLock Service That's Right for You

LifeLock Identity Theft Protection
LifeLock® identity theft protection helps proactively safeguard your personal information and alerts you of potential threats.†

LifeLock Ultimate
LifeLock Ultimate™ service is the most comprehensive identity theft protection service ever created and even includes monitoring of new and existing checking and savings accounts.†

How to enroll:

1. Learn more & enroll online at: http://arona.excelsiorenroll.com
2. Provide the name, Social Security number, date of birth, address, email and phone number for you and each dependent you wish to enroll.††
3. Select your level of coverage.*
4. Your LifeLock coverage will begin on the 1st of the month following the successful completion of your enrollment.
5. You will receive a welcome email from LifeLock with instructions on how to take full advantage of your LifeLock membership.

Enroll in LifeLock service during open enrollment and secure your personal information.

Special Employee Benefit Rate

Starting as low as
$4.25
per pay period***

LifeLock Service Payroll Deduction Pricing –

Plan Options		LifeLock Identity Theft Protection	LifeLock Ultimate
	Employee Only [18 and over]	$4.25	$10.63
	Employee + Spouse	$8.50	$21.25
	Employee + Children**	$7.44	$15.41
	Employee + Family**	$11.69	$26.03

**As LifeLock Identity Theft Protection and LifeLock Ultimate service are available for adults 18 years of age and older, children under the age of 18 will receive a product designed specifically for minors. Enrollment in LifeLock service is limited to employees and their eligible dependents.

Service Features	LifeLock Identity Theft Protection	LifeLock Ultimate
Proactive Protection	✓	✓
Credit Application Alerts†	✓	✓
Non-Credit Alerts†	✓	✓
Lost Wallet Protection	✓	✓
Address Change Verification	✓	✓
Black Market Website Surveillance	✓	✓
Reduced Pre-Approved Credit Card Offers	✓	✓
Award-Winning Member Service 24/7/365	✓	✓
$1 Million Total Service Guarantee‡	✓	✓
Alias Name and Address Monitoring		✓
Court Records Scanning		✓
File-Sharing Network Searches		✓
Unauthorized Payday Loan Notifications		✓
Sex Offender Registry Reports		✓
Checking and Savings Account Application Alerts†		✓
Bank Account Takeover Alerts†		✓
Enhanced Credit Application Alerts†		✓
Online Annual Credit Reports and Scores		✓
Monthly Credit Score Tracking		✓
Priority Award-Winning Member Service 24/7/365		✓

†Network does not cover all transactions and scope may vary.
††This information is required to receive LifeLock alerts.
*Must agree to the terms and conditions available at LifeLock.com/terms.
‡The benefits under the Service Guarantee are provided under a Master Insurance Policy underwritten by State National Insurance Company. As this is only a summary please see the actual policy for applicable terms and restrictions at LifeLock.com.

IMPORTANT NOTICE FROM THE COMPANY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Company has determined that the prescription drug coverage offered by all plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The Company coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current The Company coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	01/01/2022
Name of Entity/Sender:	Arona Corporation
Contact--Position/Office:	Amy Linn, Director of Human Resources
Address:	1001 Grand Avenue, West Des Moines, IA 50265
Phone Number:	(515) 225-9029

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage (including Medicaid and State Child Health Coverage)
If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth or Adoption
If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or State Child Health Coverage
If you or your dependents lose eligibility for coverage under Medicaid or State Child Health Coverage Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP or the determination of eligibility for a premium assistance subsidy.

> Example: When you are hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.